I. INTRODUCTION

A. Scope

All state employees attached to this department, regardless of merit status or type of employment, are covered under the state's self-insured workers' compensation fund and program. Coverage under this program is not extended to non-state employees who may be performing work within this agency on a volunteer basis or who are officially employed by a state university.

B. Purpose

The Workers' Compensation Law is designed to compensate employees for loss of earning power due to work-related injuries or diseases, arising out of and in the course and scope of their employment. This coverage includes both medical expenses and loss-time payments to an employee who is unable to work for an extended period of time due to a compensable injury or disease.

II. BENEFITS

A. 101 KAR 2:140, Section 4(1)

(a)"The required medical expense for a service rendered by a hospital or doctor, or for a prescribed medication shall be paid subject to approval of the claim.
(b) A percentage of the employee's average weekly wage shall be paid if he is unable to work for an extended period due to a job-related injury or illness.
(c)(1) Except as provided in this subparagraph, compensation shall not be payable for the first seven (7) days of disability.
(c)(2) If the disability continues over two (2) weeks, compensation shall be allowed from the first day of disability."

NOTE: In case of death due to a work-related injury or illness, benefits are provided under workers' compensation for the dependents of an employee.

III. SICK LEAVE AND WORKERS' COMPENSATION

A. 101 KAR 2:140, Section 4(2)

This regulation stipulates that "For an absence due to illness or injury for which workers compensation benefits are received, if the employee elects to accept the workers'

compensation benefits, accumulated sick leave may be used in order to maintain regular full salary. If paid sick leave is used, workers' compensation pay benefits shall be assigned back to the state for whatever period of time an employee received paid sick leave. An employee shall not receive paid sick leave and workers compensation pay for the same period of time."

B. Sick Leave - Workers' Compensation Form

An employee is entitled to use sick leave following a workers' compensation illness or injury only if the employee assigns their benefit check to the agency. To acknowledge this requirement, the employee must complete a Sick Leave - Workers' Compensation Form and forward it to the payroll office prior to receiving sick leave. If loss-time benefits are awarded, the employees' sick leave shall be restored to the extent that benefits were assigned.

IV. PROCEDURES

A. Employees' Requirements

For Workers' Compensation benefits, the most important requirement of the employee is "to notify his/her supervisor as soon as practicable after the happening thereof" (KRS 342.185). This means that an employee shall inform the supervisor of an injury as soon as physically able to do so.

In addition to notifying his supervisor, the employee is responsible for completing the following paperwork:

1) Assisting the supervisor in completing the **Workers Compensation First Report of Injury or Illness Form (IA-1)** and reading and signing the back of the form indicating the paragraph pertaining to Kentucky Law has been read and understands that filing a fraudulent claim is a crime.

2) **Medical Waiver and Consent Form (Form 106).** This completed form is to be submitted to the Workers' Compensation Coordinator.

NOTE: The next form is to be obtained from the agency Workers' Compensation Coordinator before the employee seeks medical treatment:

3) **Report of Medical Status Form (WCF-5).** This form was designed so that the employee's medical care can be more effectively monitored. The employee is to give this form to the treating physician to be completed and returned to the agency coordinator.

If an injury/illness requires outpatient surgery or planned admission to the hospital it is the employee's responsibility to notify the physician of certification procedures.

Certification may be obtained by calling Cathy Clark (502) 564-6846.

B. Supervisor's Requirement

When a supervisor has knowledge of a work-related injury to one of his/her employees, the following are the supervisors' responsibilities:

1) Obtain all pertinent information from the employee needed to complete a Workers' Compensation First Report of Injury or Illness Form **(IA-1)**. Once this information is obtained the supervisor must immediately contact the State Workers' Compensation Office at **564-2226** or **564-2307** in order to file the report. **A sample of information required when filing the report is contained at the end of this section**. The reporting time will be Monday through Friday 8:30 AM to 4:30 PM. If the injury occurs on the weekend, the injury must be reported at the beginning of the next working day. This report should be made immediately as there is a time requirement on making the first payment to the injured employee which cannot be met if the injury report is not received promptly. The agency's Workers' Compensation Coordinator should be advised of the injury and report. The Coordinator should also be provided the employee signature page of the form.

   NOTE: If the report is not made immediately the agency will be subjected to a fine of not more that $1,000.00 pursuant to KRS 342.990 (8).

2) If the employee is off work longer than the initial day of injury, then it is necessary for the supervisor to complete a Loss of Time and Return to Work Form **(WCF-1)** and submit it to the agency coordinator. The supervisor must also notify the agency coordinator when the employee returns to work.

3) Whenever possible, direct the employee to the Workers' Compensation Coordinator before the employee seeks medical treatment for a work-related injury or illness so the employee can be provided with the appropriate paperwork.

C. Workers' Compensation Coordinator Requirements

1) To maintain a supply of the forms necessary to administer this program and to make them available to supervisors and employees upon request.

2) To forward the signature page of the Workers' Compensation First Report of Injury or Illness Form (IA-1), the Medical Waiver and Consent Form (Form 106), the Report of Medical Status (WCF-5) and any other related information (i.e. medical bills, disability statements, etc.) to the State Workers' Compensation Office.

3) To submit a Lost Time and Return to Work (Form WCF-1) to the State Workers' Compensation Office upon being notified by the supervisor that an employee has lost time and/or returned to work.

4) To provide the employee with a Sick Leave - Workers' Compensation Form when he/she will use sick leave for a work-related injury/illness and to submit completed form to the Payroll Office.

5) To maintain a file copy of all reports submitted and to complete the U.S. Department of Labor OSHA report #200-S on an annual basis.

NOTE: All of the above mentioned forms are contained at the end of this section for review.

D. Medical Bills

The use of the Medical Certification Card, which is provided to the employee by the third party administrator, should ensure that all medical bills for a work-related injury or illness are submitted directly to the Workers' Compensation Office in the Personnel Cabinet. However, some providers (particularly pharmacies) will not bill Workers' Compensation directly. In these cases, the employee must pay the bill, then bring the receipt to the Workers' Compensation Coordinator. The bill will be sent to the state Workers' Compensation office and the employee will be reimbursed as soon as the claim is approved.

E. Accident Prevention

Management, which includes all supervisors, has the responsibility for every operational activity of their department, and each supervisor must accept his/her share of the responsibility for the safety of his/her employees.

It is a basic principle of the Commonwealth's safety philosophy that each organization is responsible for safety and that each employee, in accepting his/her job, assumes a personal responsibility for work safety. An understanding must be secured with each employee that compliance with safety requirements is a condition of his employment.

SUPERVISOR'S ACCIDENT INVESTIGATION REPORT

CABINET: _____ TIME EMPLOYED ON THIS JOB: _____

DEPARTMENT: _____ DATE OF ACCIDENT: _____

ADDRESS: _____ TIME OF ACCIDENT: _____

EMPLOYEE NAME: _____ PLACE OF ACCIDENT: _____

JOB TITLE: _____ _____

_____

BODY PART INJURED

Head_____	Neck_____	Arm_____	Leg_____	Foot_____
Face_____	Back_____	Hand____	Knee_____	Toe_____
Eye_____	Chest_____	Finger___	Ankle____	Other_____

NATURE OF INJURY

Abrasion_____	Sprain/Strain_____	Heat Injury_____
Laceration_____	Foreign Body_____	Cold Injury_____
Puncture_____	Burn_____	Loss of Consciousness_____
Bruise_____	Dermatitis_____	Other_____

ACTION TAKEN:

_____First Aid Only
_____Physician – NAME:_____
_____Emergency
_____Hospital

Employee's statement of accident: (Include what you were doing, what happened, and cause)

_____
_____
_____
_____
_____

Was personal protective equipment being used? _____ What? _____

Employee's Signature:_____Date:_____

UNSAFE CONDITIONS

_____Improperly guarded equipment or machine
_____Defective tool or equipment
_____Poor housekeeping
_____Improper lighting
_____Improper ventilation
_____Unsafe design or construction
_____Slippery or other unsafe surface
_____Inadequate warning system
_____Hazardous storage or arrange-
_____Hazardous weather or environment
_____Hazardous dress or apparel
_____Hazardous work procedures
_____Combative person or injury to arresting officer
_____Contact with poisonous plants, insects, toxic chemicals, skin irritants, bites, etc.
_____Investigation reveals that accident was beyond control of injured employee
_____Other:_____

UNSAFE ACTS

_____Operating without authority
_____Failure to warn others
_____Operating at unsafe speed
_____Making safety devices inoperable
_____Failure to secure objects
_____Using unsafe equipment or equipment unsafely
_____Unsafe loading, mixing, carrying
_____Taking unsafe position or post
_____Working on moving or dangerous equipment
_____Distracting others
_____Failure to use personal protective devices
_____Failure to observe safety regulations
_____Lack of training or knowledge
_____Preventive vehicle accident
_____Slips and falls
_____Others: _____

REASONS FOR UNSAFE ACT:_____
_____
_____

REASONS FOR UNSAFE CONDITION:_____
_____
_____

DID ACT OCCUR BECAUSE EMPLOYEE:
1. Did Not Know ( )
2. Had Attitude Problem ( )
3. Physical difficulty ( )
4. Other ( )_____

WHAT PRACTICAL CORRECTIVE ACTION HAS OR WILL BE TAKEN BY SUPERVISOR TO PREVENT RECURRENCE?_____
_____
_____

NAME OF WITNESS:_____
DOES WITNESS'S ACCOUNT OF ACCIDENT AGREE WITH THAT OF EMPLOYEE?_____IF NOT, INCLUDE WITNESS'S ACCOUNT ON SEPARATE PAGE.

SUPERVISOR'S SIGNATURE:_____DATE: _____

DEPARTMENT HEAD SIGNATURE: _____DATE:_____

COPIES: State Safety Director_____, Agency Safety Representative_____

SAFETY MEETING REPORT

Department _____ Person Conducting Meeting_____

Division _____ Title _____

Meeting Date _____ Meeting Location _____

Attendance Number _____ _____

Meeting Time _____ (Minutes)

ORDER OF BUSINESS

Subjects Discussed:_____
_____
_____
_____
_____

Injuries-Accidents Reviewed: _____
_____
_____
_____
_____

Suggestions Offered:_____
_____
_____
_____
_____

Action Taken:_____
_____
_____
_____
_____

COPIES TO: Agency Safety Representative_____, Department Director_____